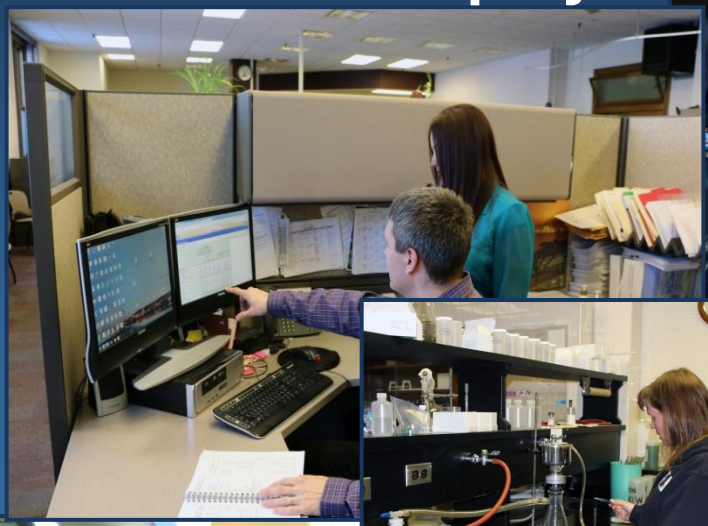
THE CITY OF

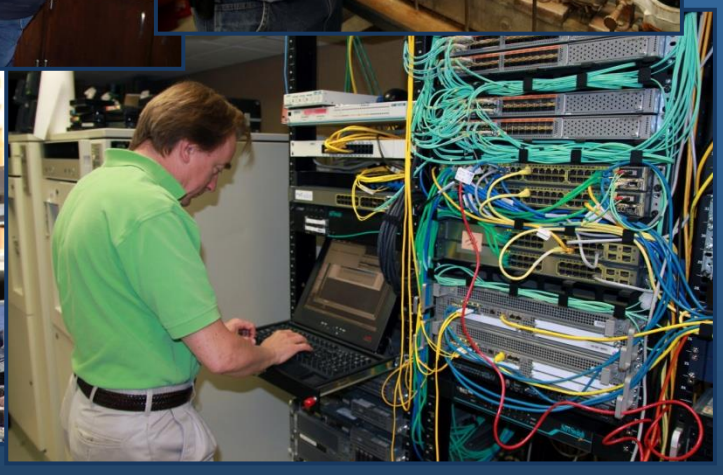
DULUTH

MINNESOTA

2015 Employee Benefits Guide








Our employees are our most valuable asset

At the City of Duluth/Joint Powers Enterprise Trust, we are committed to a comprehensive employee benefits program that helps our employees stay healthy, feel secure and maintain a positive work/life balance.

Any questions, concerns or suggestions regarding these benefits can be directed to Human Resources at **(218) 730-5210** or emailed to hrinformation@duluthmn.gov.

Line of Coverage	Administrator	Policy	Phone	Email/Website
Health	HealthPartners	25077	1-800-883-2177	www.healthpartners.com/cityofduluth
Pharmacy	ClearScript		1-800-546-5677	www.clearscript.org
Dental	Delta Dental of Minnesota	000405	1-800-553-9536	www.deltadentalmn.org
Life and AD&D	Minnesota Life	28410	1-800-843-8358	https://www.minnesotalife.com/
Flexible Spending Accounts (FSA)	TASC	4206-0669-6120	1-800-422-4661	www.tasconline.com
Employee Assistance Program	Midwest EAP	N/A	1-800-383-1908	www.midwesteap.com
City of Duluth Human Resources	Human Resources Front Desk Leighann Severance Keely Downs Shannon Sweeney		218-730-5210 218-730-5213 218-730-5197 218-730-5198	hrinformation@duluthmn.gov www.duluthmn.gov/employment

Important Reminders

- Open Enrollment begins **Monday, November 3, 2014** and closes **Monday, November 17**, **2014 at 4:30 PM**. Open enrollment meetings will be held during this year's Bridge to Wellness Health Fair on **Wednesday, November 5 from 8 AM to 3 PM**. You can find more information about the health fair at http://www.duluthmn.gov/bridge-to-wellness/.

- **The 2015 Open Enrollment is a "passive enrollment" with the exception of your Flexible Spending Account (FSA) elections.** Passive enrollment means that if you are satisfied with your health and dental benefit plan coverage and elections, you **do not** need to submit a benefits enrollment form. If you wish to make changes to your coverage or election tier, you must submit a benefits enrollment form by **4:30 PM on Monday, November 17th.**

- You will not be able to make any benefit changes until the next open enrollment unless you experience a qualifying life event – some examples are:
  - Marriage or divorce
  - Birth/adoption
  - Death of a spouse/child
  - Loss of coverage through another plan

  Be sure to review your January pay stubs as a verification of enrollment. It is your responsibility to ensure that the deductions for your benefit elections are correct. If you find a discrepancy, notify Human Resources immediately.

- **Open Enrollment is a good time to verify your life insurance beneficiary information reflects your current status and chosen beneficiaries.**

- **Pharmacy ID Cards:** Participants covered under the medical plan with ClearScript for pharmacy will receive new ClearScript ID cards. Those cards will be effective January 1st. 2015. Please continue to use your current cards until December 31st of 2014.

- **FSA Participants:** You will receive a new MyTASC card from TASC/Genesis for use with your FSA beginning January 1st, 2015. More education and information regarding the MyTASC Card will be provided in December for those who are contributing to Flexible Spending Accounts for the 2015 plan year.

- **Pay Periods:** Deductions for medical premiums, dental premiums, and flexible spending accounts will be made over 24 pay periods on the first and second paycheck each month. In months that contain a third paycheck, no premium deductions will be withheld from the third paycheck.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

Medical Insurance

Administered by HealthPartners

Eligibility

The collective bargaining agreements determine benefit eligibility. Under current collective bargaining agreement language, all City of Duluth regular full-time and part-time employees are benefit eligible. Eligible dependents include your legally married spouse and eligible children up to age 26. Please refer to your CBA for contract specific eligibility language.

Network

Your plan utilizes HealthPartners' **Open Access Network**. This allows you access to a wide range of providers. Although your benefit is the same, your out-of-pocket responsibility will be less when you use an in-network provider. Go online to **www.HealthPartners.com/cityofduluth** and click on 'Find a doctor or specialist' to see if a provider is in-network.

Medical Plan Costs

Single Coverage		Monthly	Per Paycheck*
Total Single Premium		$697.00	$348.50
City Contribution – 90% of Single premium		($627.30)	($313.65)
Employee Contribution – 10% of Single premium		$69.70	$34.85
Basic, Fire, Police, LELS & Supervisory Employees	Total Cafeteria Plan Contribution	$304.00	$152.00
	Less employee responsibility	($69.70)	($34.85)
	Remaining Cafeteria Plan Contribution	**$234.30**	**$117.15**
Confidential Employees	Total Cafeteria Plan Contribution	$320.00	$160.00
	Less employee responsibility	($69.70)	($34.85)
	Remaining Cafeteria Plan Contribution	**$250.30**	**$125.15**

Family Coverage		Monthly	Per Paycheck*
Total Family Premium		$1,715.00	$857.50
City Contribution – 80% of Family premium		($1,372.00)	($686.00)
Employee Contribution – 20% of Family premium		$343.00	$171.50
Basic, Fire, Police, LELS & Supervisory Employees	Employee Responsibility	$343.00	$171.50
	Less Cafeteria Plan Contribution	($229.00)	($114.50)
	Remaining Employee Responsibility	**$114.00**	**$57.00**
Confidential Employees	Employee Responsibility	$343.00	$171.50
	Less Cafeteria Plan Contribution	($245.00)	($122.50)
	Remaining Employee Responsibility	**$98.00**	**$49.00**

*****Per-Paycheck amounts for health premiums and cafeteria plan contributions are calculated using 24 pay periods; in months that contain a third paycheck, no premium deductions will be held from the third employee paycheck.

Medical Plan Benefits

Covered Services		In and Out of Network
Annual Deductible	Single	$250
	Family	$500
Coinsurance		Plan pays 80%
Out-of-Pocket Maximum	Single	$1,250
	Family	$2,500
Office Visits		
Primary Care Office Visit Specialist Visit Chiropractor Visit Urgent Care		You pay 20% after deductible
Virtuwell Online Care		You pay 20%, no deductible
Convenience Care		You pay 20%, no deductible
Preventive Care		No charge
Prenatal and Postnatal care		No charge
Prescription Drugs		
Retail Pharmacy 34 day supply or 100 units	Generic	No charge
	Formulary Brand	$15 copay
	Non-Formulary Brand	You pay 30% $30 min / $100 max
Specialty Drugs		You pay 30% $30 min / $100 max
Hospital Services		
Emergency Room		You pay 20% after deductible
Ambulance		You pay 20% after deductible
Inpatient Hospital Services		You pay 20% after deductible
Facility/Physician Services		You pay 20% after deductible
Outpatient Services		You pay 20% after deductible
Other Services		
Home Health Care		You pay 20% after deductible
Behavioral Health / Substance Abuse		You pay 20% after deductible
Durable Medical Equipment		You pay 20% after deductible

The above is a listing of the main services of your plan. For a detailed and complete listing, please refer to your plan documents.

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Dental Insurance

Administered by Delta Dental of Minnesota

Eligibility

The collective bargaining agreements determine benefit eligibility. Under current collective bargaining agreement language, all City of Duluth regular full-time and part-time employees are benefit eligible. Eligible dependents include your legally married spouse and eligible children up to age 26. Please refer to your CBA for contract specific eligibility language.

Network

Your plan utilizes the Delta Dental PPO and Premier Networks, two of the widest dental networks in the state. You can review the list of participating dentists online; click to www.deltadentalmn.org and click on 'Find a Dentist."

Benefits

You have a choice of two different plan options:

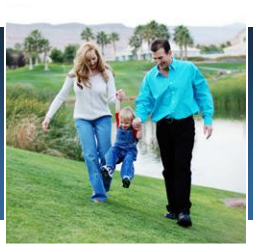
Covered Services	Low Option	High Option
Annual Deductible	None	None
Annual Plan Maximum	$1,000	$2,000
Diagnostic / Preventive Care	100%, no charge	100%, no charge
Basic Services		
Fillings	You pay 20%	You pay 20%
Restorations	You pay 20%	You pay 20%
Endodontic Therapy	You pay 20%	You pay 20%
Periodontics	You pay 20%	You pay 20%
Oral Surgery	You pay 20%	You pay 20%
Major Services		
Major Restorative Care	You pay 20%	You pay 20%
Prosthetic Repair/Adjustment	You pay 20%	You pay 20%
Prosthetics	You pay 50%	You pay 50%

Dental Plan Costs

Plan	Low Option ($1,000 Annual Benefit)			High Option ($2,000 Annual Benefit)		
	Monthly Premium	City Contribution	Employee Contribution	Monthly Premium	City Contribution	Employee Contribution
Single	$31.00	$31.00	$0.00	$63.00	$31.00	$32.00
Single + 1	$62.00	$31.00	$31.00	$119.00	$31.00	$88.00
Family	$102.00	$31.00	$71.00	$211.00	$31.00	$180.00

Life and AD&D Insurance

Insured by Minnesota Life



Eligibility

The collective bargaining agreements determine benefit eligibility. Under current collective bargaining agreement language, all City of Duluth regular full-time and part-time employees are benefit-eligible. Eligible dependents include your legally married spouse and eligible children up to age 25. Please refer to your CBA for contract specific eligibility language.

Supplemental Life and AD&D Insurance	
Employee	Elect up to $300,000 of life coverage with matching AD&D Choose your coverage in $5,000 units Evidence of insurability is required
Spouse	Elect up to $150,000 of life coverage with matching AD&D Choose your coverage in $2,500 units, subject to a minimum of $5,000 Evidence of insurability is required A spouse is ineligible if he/she is eligible as an employee of the City
Child	Choose a flat benefit of $10,000 One premium covers all eligible children from 14 days to 19 years (up to 25 years if a full-time student) Evidence of insurability is required.

Monthly Plan Cost

Age	Employee Cost per $5,000	Spouse Cost per $2,500	Child Cost
Under 25	**$0.50**	**$0.25**	**$1.30 per month covers all eligible children**
25-29	**$0.50**	**$0.25**	
30-34	**$0.60**	**$0.30**	
35-39	**$0.60**	**$0.30**	
40-44	**$0.90**	**$0.45**	
45-49	**$1.40**	**$0.70**	
50-54	**$2.40**	**$1.20**	
55-59	**$3.90**	**$1.95**	
60-64	**$4.30**	**$2.15**	
65-69	**$8.30**	**$4.15**	
70-74	**$15.00**	**$7.50**	

Flexible Spending Accounts

Administered by TASC

Flexible Spending Accounts, known as FSAs, are a great way to save on predictable medical, dental and vision costs – even dependent daycare expenses. These tax-advantaged accounts allow you to save a portion of your pre-tax earnings, lower your taxable income, and reimburse yourself for the expenses you know you will incur.

During your annual enrollment period, you decide how much you want to contribute, and a pro-rated portion is taken out of your paycheck each pay period. Once you incur expenses, you can access your funds conveniently with your MyTASC debit card.

You have two account options available for contributions – a health care FSA and a dependent care FSA. Each type of account offers different benefits and operates under similar guidelines.

Health Care Flexible Spending Account

This program lets you pay for certain medical, dental and vision expenses with pretax funds.
The annual limit for 2015 is $2,500. Some examples include:

- Deductibles, office visits, and prescription drugs
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services

For a comprehensive list, go online to www.tasconline.com and click on "Eligible Expenses"

Dependent Care Flexible Spending Account

This program lets you use pretax funds for qualified dependent care, like daycare or elder care.
The annual limit for 2015 is $5,000 (or $2,500 if married and filing separately). Some examples:

- Day camp (if primarily custodial and not educational in nature)
- Dependent care necessary for you and your spouse to work or attend school full time
- Care for children under age 13 or for elderly dependents who reside with you
- Nanny expenses, late pick-up fees

USE IT OR LOSE IT! Plan your contributions carefully. FSA funds can only be used for expenses that are incurred during the plan year (January through December 2015). You may file claims for those funds up to 60 days after the plan year. **Any Dependent Care FSA funds not used are forfeited. The Health Care FSA allows a $500.00 carryover, but any unused Health Care FSA amounts above $500.00 are forfeited.**

IMPORTANT! If you, or your spouse, are enrolled in a high-deductible health plan offered by another employer and you are contributing to a Health Savings Account, you may be ineligible to contribute to an FSA. Contact Human Resources for more information.

General Notice of COBRA Continuation Coverage Rights

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Duluth, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Beginning April 1, 2009, two additional special enrollment events are available to you and your eligible dependents. They are:

1. **Becoming ineligible for Medicaid or the Children's Health Insurance Program (CHIP)**. If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the City of Duluth plan. You must request enrollment within 60 days

2. **Becoming eligible for Premium Assistance through Medicaid or CHIP.** If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the City of Duluth plan. You must request enrollment within 60 days.

For more details about these special enrollment opportunities, please consult your summary plan description. To request special enrollment, contact Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility.

MINNESOTA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under Federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Our plan complies with these requirements. Benefits for these items generally are comparable for those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician.

Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, contact Human Resources

Notice of Privacy Reminder

The City of Duluth is subject to HIPAA privacy rules. In compliance with these rules, it maintains a notice of privacy practices. You have the right to request a copy of the notice of privacy practices by contacting Human Resources.

Summary of Benefits and Coverage

As required by the Patient Protection and Affordable Care Act, Summary of Benefits and Coverage (SBC) for the City of Duluth medical plan are available upon request. You have the right to request a copy of this document by contacting Human Resources